STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185409	A. BUILDING _____ B. WING _____	09/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW CARE AND REHABILITATION CENTER	1871 MIDLAND TRAIL SHELBYVILLE, KY 40065

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 20 Manager further stated that she was aware that LPN #1 used contaminated scissors and that she encouraged the nurses to use sterile kits for scissor use. Interview on 09/02/10 at 7:00pm with the Director of Nursing (DON) revealed she has in-serviced on infection control and skills are done when hired by the company. If there is an issue with the nursing skills, they usually have another nurse to show how it should be done. The DON further stated that cross contamination is an infection control issue and a wound can become more infected. Observations of Resident #1 on 09/01/10 at 9:30am during peri-care revealed CNA #2, and CNA #3 both washed hands, put on their gloves then began preparation of peri-care to the resident. Once the CNAs put the gloves on their hands, they proceeded to put the window blinds down, touched lines, residents clothing, removed resident's brief and continued to proceed with peri-care. The CNAs did not remove the dirty gloves, wash hands or apply cleans gloves as he/she proceeded with peri-care. Interview with CNA #2 and CNA #3 on 09/01/10 at 9:30am revealed they should not have touched the window blinds, all the lines, the brief, and then continued to do the peri-care with the same gloves. They both reported they should have removed the dirty gloves, washed their hands and put on clean gloves to do the peri-care for the resident. Observation of Resident #9 during wound care treatment and dressing change on 09/02/10 at 10:44am revealed Registered Nurse (RN) #3 prepared the wound packing at the treatment cart	F 441		

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F 441	Continued From page 21 at the resident's door entrance. The RN had on clean gloves when he/she added the gauze and solution to a blue cup for the wound packing. The RN wore the same gloves, picked up the trash on her/his treatment cart, placed paper items in trash, used both hands to close the treatment cart drawers and doors, then proceed with the same gloved hands to pick up the cup with the prepared wound packing in it. RN #3 took the blue cup with the treatment and solution over to the sink, put a forfinger into it, tilted it, and expressed the excess fluids from the cup. RN #3 proceeded to the beside of the resident to continue the dressing change and to place the packing, that had been touched by the dirty gloved finger, in the wound. Interview with RN #3 at 09/02/10 at 10:46 revealed the wound care should be a clean procedure and she/he reported the gloves he/she wore should have been changed, and his/her hands should have been washed, and clean gloves used during the dressing change. She/He reported the wound packing was contaminated when she/he put their finger into the cup to express the extra fluid out of the cup.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	F 514 1. Resident # 3 was re-assessed by Unit Manager on 9/2/10 to accurately reflect the current condition of the wound site. The treatment order for the resident was updated to reflect current staging of wound.	

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F 514	Continued From page 22 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to maintain clinical records for one (1) of nineteen (19) sampled residents (Resident #3). The facility failed to document in the medical record a Stage III wound when it had worsened from an abrasion. The findings include: Record review of Resident #3's treatment to coccyx revealed he/she was to receive a treatment to an abrasion to the coccyx, cleanse it with wound cleaner, apply alginate and cover with dry dressing twice a day and as needed. The start date indicated was 08/19/10. Interview with License Practical Nurse (LPN) #1 on 09/02/10 at 7:30am revealed during a dressing change Resident #3 had a Stage III wound to his/her coccyx, and not an abrasion. Observation on 09/02/10 at 7:30am of the Stage III wound to Resident #3's coccyx revealed the wound was 1.8cm deep with no visible bone present. Interview with the Unit Manager on 09/02/10 at 5:42pm revealed that when Resident #3 was admitted the wound showed an excoriation to the coccyx and buttocks area. The abrasion turned into a wound quickly due to a decrease in mobility and a decrease in the amount of food Resident #3 consumed. The Unit Manager further stated	F 514	2. Residents who have pressure ulcers will have their medical records reviewed by DNS and/or unit manager on or before 9/24/10 to ensure accurate staging of wounds and treatment orders to reflect such. 3. The nursing staff will be re-educated by DNS on or before 09/30/10 on staging and the need for the treatment order to reflect appropriate stage of wounds. 4. DNS and/or unit manager will review pressure ulcer documentation and treatment orders for correct staging weekly for four (4) weeks then monthly for (2) two months. The DNS and/or unit manager will review trends in the Performance Improvement Committee meeting monthly for three (3) months for discussion and review 5. Date of Compliance: October 11, 2010.	

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F 514	Continued From page 23 that she does not know why the wound sheet had not been changed to meet the residents current condition. Interview with the Director of Nursing (DON) on 09/02/10 at 7:00pm revealed that the treatment sheet was not accurate and staff should document that Resident #3 had a Stage II or III on the treatment record..	F 514		

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	185409	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/31/2010

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/31/10. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain access doors located in smoke barriers according to NFPA standards. Smoke barriers must be maintained to limit the spread of smoke and flames in the event of a fire. The findings include: Observation on 08/31/10 at 11:18pm, revealed one (1) makeshift door in a smoke barrier located in the front hallway attic. The observation was confirmed with the Maintenance Director.	K 025	K025 1. No residents were adversely affected. 2. All residents had the potential to be affected. 3. The 2' X 2' door will be covered on both sides with metal plates. The Maintenance Director will check all barrier doors monthly as part of a PM program. 4. Results of the monthly barrier door check will be brought to PI by the Maintenance Director for three (3) months for discussion and review. 5. Date of Compliance: October 11, 2010.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve McFarlee | TITLE: Administrator | (X6) DATE: 9/27/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 Interview on 08/31/10 at 11:18pm, with the Maintenance Director, revealed the Maintenance Director believed the door in the smoke barrier met code. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047	K047 1. No residents were adversely affected. The exit sign bulbs were replaced on 9/1/10.	

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K 047	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained according to NFPA standards. Exit signs must be maintained so exits will be noticed in the event of an emergency. The findings include: Observation on 08/31/10 at 12:03pm revealed that an exit sign in the Front Hall did not have working bulbs. The observation was confirmed with the Maintenance Director. Interview on 08/31/10 at 12:03pm, with the Maintenance Director, revealed he checks the exit signs daily, but was unaware of the exit sign in the Front Hall not working. Reference: NFPA 101 (2000 edition) 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception:* Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system.	K 047	2. All residents had the potential to be affected. The Maintenance Director completed facility rounds reviewing exit signs on 9/1/10. No other exit sign bulbs were found to be non-functioning. 3. The Maintenance Director will check all exit signs weekly for three (3) months. 4. Results/trends of the weekly checks will be brought to PI for three (3) months by the Maintenance Director for discussion and review. 5. Date of Compliance: October 11, 2010.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056	K056 1. No residents were adversely affected.	

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K 056	Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that outside canopies at the facility were of noncombustible or limited combustible construction or sprinkler protected according to NFPA standards. The findings include: Observation on 08/31/10 at 2:13pm revealed a canopy approximately five (5) feet by fifteen (15) feet at the side exit that was made of combustible material. Further observation revealed a total of three (3) more canopies of combustible construction that were not sprinkler protected. The areas included the front canopy, approximately eight (8) feet by twenty five (25) feet, living room, approximately seven (7) feet by fifteen (15) feet, and the smoking area, approximately ten (10) feet by fifteen (15) feet. The observations were confirmed with the Maintenance Director. Interview on 08/31/10 at 2:13pm, with the Maintenance Director, revealed he believed the canopies met Life Safety Code requirements.	K 056	2. All residents had the potential to be affected. All other facility canopies were reviewed on 09/1/10 by the Maintenance Director and no others were found to require sprinkler protection. 3. The Maintenance Supervisor was re-educated by the Administrator on 9/24/10 regarding the sprinkler protection requirement for canopies over 4 feet wide. The facility is in the process of acquiring bids to add sprinkler protection to the four identified canopies. One will be selected and the four canopies will have sprinkle protection installed per code. The Maintenance Director will monitor monthly for three (3) months. 4. Results will be brought to PI by the Maintenance Director for three (3) months for discussion and review. 5. Date of Compliance: October 11, 2010.	

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K 056	Continued From page 4 Reference: NFPA 13 (1999 Edition). 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator, according to NFPA standards. The findings include: Observation on 08/31/10 at 1:40pm revealed the transfer switch for the emergency generator did not have emergency battery powered lighting. The observation was confirmed with the Maintenance Director.	K 144	K144 1. No residents were adversely affected. The Maintenance Director installed battery-powered lighting to the transfer switch area on 9/1/10. 2. All residents had the potential to be affected, 3. The Maintenance Director was re-educated by the Administrator on 9/24/10 regarding the requirement of battery-powered emergency lighting near the transfer switch. The Maintenance Director will monitor the battery-powered emergency lighting to transfer switch weekly for three (3) months. 4. Results/trends will be brought to PI by the Maintenance Director for discussion and review. 5. Date of Compliance: October 11, 2010.	

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K 144	Continued From page 5 Interview on 08/31/10 at 1:40pm, with the Maintenance Director, revealed he was unaware of the requirement to have emergency battery powered lighting for the emergency generator transfer switch. Reference: NFPA 110 (1999 edition) 5-3 Lighting. 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 144		

ADDENDUM TO K025: Paragraph #3 – The 2' x 2' door will be replaced by a fire-rated door. The Maintenance Director will order the door and the door will be replaced when acquired. The Maintenance Director will check all barrier doors monthly, as part of the PM program.

Sincerely,

Steve McKinley, LNHA
Administrator

October 7, 2010

Office of Inspector General
L & N Building
908 West Broadway, Second Floor West
Louisville, KY 40203

Attention: Millie Zumstein, Regional Program Director

Attached are the changes to our Plan of Correction as requested:

ADDENDUM TO F241/N113: Paragraph 4 – The DNS and or Unit Manager will conduct rounds three (3) times weekly, then one time a week for four (4) weeks, then monthly for 3 months. The rounds will be conducted regarding dignity and respect of individuality and will include assessment of providing privacy and ensuring dignity bags are in use to cover catheter bags. Identified problems will be rectified immediately. The DNS will report trends in the Performance Improvement Committee meeting monthly for three (3) months and thereafter, as indicated by findings.

ADDENDUM TO F253/N134: Paragraph #3 – "The Environmental Service Supervisor and the Maintenance Director were educated by the Administrator on 9-24-10 regarding how to develop a tracking tool to use in order to document self-identification needs of the facility for their respective areas of responsibility. The Environmental Services Supervisor and Maintenance Director will add identified areas to the regular cleaning schedule and PM schedule and will monitor and document cleaning and maintenance of equipment is taking place weekly for three (3) months. Additionally, the Environmental Service Supervisor and Maintenance Director will complete a monthly room audit to self-identify areas of need. The audits will include ensuring dining room furniture is clean, wheelchair arm rests are in good repair, the fish tank is clean, and resident equipment is not soiled and is maintained. Identified problems will be rectified immediately.

Paragraph #4 - The Environmental Services Supervisor and Maintenance Director will report trends from their respective audits in the Performance Improvement Committee meeting monthly for three (3) months and thereafter, as indicated by findings.

ADDENDUM TO F279/N185: Paragraph #4 – The DNS and/or Unit Manager will review 5 resident care plans weekly times four (4) weeks, then monthly time two (2) months to ensure interventions implemented are effective for individual residents. Identified problems will be rectified immediately. The DNS and/or unit manager will

review trends in the Performance Improvement Committee meeting monthly for three (3) months and thereafter, as indicated by findings.

ADDENDUM TO F323/N220: Paragraph #4 – The DNS and or unit manager will review five (5) residents care plans weekly for four (4) weeks, then monthly for two (2) months to ensure current interventions and assistive devices are in place to prevent accidents. Identified problems will be rectified immediately. The DNS and or unit manager will review trends in the Performance Improvement Committee meeting monthly for three (3) months and thereafter, as indicated by findings.

ADDENDUM TO F371/N283: Paragraph #4 - The Dietary Manager will monitor and document compliance with identified concerns on a daily M-F sanitation checklist and will complete a weekly, for four (4) weeks, and a monthly sanitation audit ongoing. The RD will also include these areas in her monthly sanitation audit and will review with the Dietary Manager. The Dietary Manger and/or Administrator will review trends in the Performance Improvement Committee meeting monthly for three (3) months and thereafter, as indicated by findings.

ADDENDUM TO F441/N144: Paragraph # 3-The Nursing staff will be re-educated by the DNS on or before 9/30/10 on infection control policies and procedures including: universal precautions and standard infection control practices during wound care, skin assessments, G-tube care, and peri-care, including return demonstrations. The DNS will re-educate the certified nursing assistants on peri care and each certified nursing assistant will complete a peri care competency check off on or before 10/10/10.

Paragraph #4 –The DNS and/or unit manager will monitor facility infection control practices to ensure ongoing compliance by observation of resident care weekly for four (4) weeks, then monthly for two (2) months. Identified problems will be rectified immediately. Additionally, the DNS and/or Unit Manager will complete a peri-care competency on CNA's annually, as well as completing a G-tube/wound care competency on Licensed Nurses annually. The DNS will review trends in the Performance Improvement Committee meeting monthly for three (3) months and thereafter, as indicated by findings.

ADDENDUM TO F514/N353: Paragraph #4 - The DNS and/or unit manager will review pressure ulcer documentation and treatment orders for correct staging weekly for four (4) weeks, then monthly for (2) months. Identified problems will be rectified immediately. The DNS and/or Unit Manager will review trends in the Performance Improvement Committee monthly for three (3) months and thereafter, as indicated by findings.

ADDENDUM TO B005: Paragraph #4 - The DNS and /or unit manager will review 5 residents per week for four (4) weeks, then monthly for 2 months to ensure compliance with TB skin tests. Identified problems will be rectified immediately. The DNS and/or unit manager will review trends in the Performance Improvement Committee meeting monthly for three (3) months and thereafter, as indicated by findings.